



STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
STATE BOARD OF SOCIAL WORKER LICENSURE
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
FAX:(207)624-8637

VERIFICATION OF CONSULTATION FORM
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Use a separate form for each person verifying experience and for each employment setting.
If more space is needed, attach an additional sheet. Please print clearly.

Licensee Data (To be completed in full by Licensee)		
Name of Licensee:		License Number:
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:		Original Licensure Date:
Place of Employment During Consultation Period:		

Consultant Data (To be completed in full by Consultant)		
Name of Consultant:		License Number:
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:		Home Telephone:
Consultant's Education/School:		
Year Graduated		Degree Awarded:

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Licensee Consultation Information (To be completed in full by Consultant)	
Total Number of Hours Licensee Worked Per Week	
Total Number of Hours Per Month Individual Supervision/Consultation Was Given	
Total Number of Hours Per Month Group Supervision/Consultation Was Given	
Total Number of Hours Licensee Worked During the Period Listed Below	
Dates the Applicant was Under your Supervision: From _____ To _____ <div style="text-align: center; font-size: small; margin-top: -10px;">month/day/year month/day/year</div>	
1. Please describe licensee's specific functions in terms of social work. If consultation was provided to a Master's level Social Worker, please describe applicant's functions in terms of prevention, diagnosis and treatment of mental illness/disorders and psychosocial treatment: _____ _____ _____ _____	
2. Please state briefly licensee's personal character, ethical conduct, and competence: _____ _____	
3. Do you recommend that this person be re-licensed? <input type="checkbox"/> YES <input type="checkbox"/> NO If not, please describe why: _____ _____ _____	

I ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE TO RETURN THIS FORM TO THE LICENSEE FOR MAILING TO THE BOARD OF SOCIAL WORKER LICENSURE.

Signature of Consultant: _____ Date: _____